Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

Silver AW1- AHCIP PPO - 32
Schedule of Benefits

This Schedule of Benefits is part of the Policy, Form 17-311 and
is subject to all benefit terms, conditions, limitations, and exclusions contained therein.

Lifetime Maximum – per Covered Person (all services)	No Lifetime Maximum	
Dependent Age	26	
	In-Network	**Out-of-Network**
Medical Annual Deductible - Individual	$0.00	$0.00
Prescription Drug Annual Deductible - Individual	$0.00	Not Covered
Annual Limitation on Cost Sharing - Individual	$0.00	$0.00
COVERED BENEFITS AND SERVICES	**In-Network**	**Out-of-Network**
Professional Services		
Primary Care Physician (PCP) Visits	$0	0%
Specialist Office Visit (consultation/evaluation only)	$0	0%
Services and procedures provided in the Specialist office other than consultation and evaluation	$0	0%
Preventive Health Services		
Immunizations (by PCP)	$0	Not Covered
Well Baby Care – through 12 months of age (by PCP)	$0	Not Covered
Well Child Exam – over 12 months of age (by PCP)	$0	Not Covered
Physical Exams – Adults (by PCP)	$0	Not Covered
Routine Gynecological visit (PCP or GYN)	$0	Not Covered
Mammogram and Pap Smear, PSA	$0	Not Covered
Routine Vision Exam – Pediatric (one per visit per Covered Child each calendar year)	$0	Not Covered
Bone Density	$0	Not Covered
Allergy Services		
Services provided by the PCP	$0	0%
Services provided by the Specialist	0%	0%
Hospital Services (Prior Approval Required)		
Inpatient Services -Semi-private room.	$0	0%
Outpatient Hospital Services	0%	0%
Outpatient Surgical Services	0%	0%
Emergency Care Services		
Urgent Care Center	$0	0%
Emergency Room	0%	Same as in network
Observation Services	0%	Same as in network
Ambulance Services (Ground-limited to $1,000 / trip; Air – limited to $5,000 / trip)	0%	Same as in network
Ambulatory Surgery Centers (Prior Approval Required)	0%	0%

COVERED BENEFITS AND SERVICES (CONT.)	In-Network	Out-of-Network
Outpatient Diagnostic Services		
Diagnostic Services - Lab and X-ray (Services and procedures performed outside PCP office)	0%	0%
Advanced Diagnostic Imaging Services CT Scan, PET Scan, MRI/MRA, Nuclear Cardiology **Prior Approval Required**	0%	0%
Maternity and Family Planning Services* (Prior Notification Required)		
Prenatal and Postnatal outpatient care	$0	0%
Inpatient Maternity Services	$0	0%
Infertility Counseling and Infertility Testing	0%	Not Covered
Infertility Treatment (Prior Approval Required)	0%	Not Covered
Out-of-Network Newborn coverage limited to $2,000 per Covered Person for all services (first 90 days after birth)		
Rehabilitation Services (Prior Approval Required)		
Inpatient Rehabilitation Services (Limited to 60 days per Covered Person per calendar year)	$0	Not Covered
Outpatient Rehabilitation Services: Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Covered Person per calendar year)	$0	Not Covered
Cardiac Rehabilitation (Limited to 36 visits per Covered Person per calendar year) - No coverage in Freestanding Facilities.	0%	Not Covered
Neurologic Rehabilitation Facility Services (Prior Approval Required) – Limited to 60 days per lifetime.	0%	0%
Habilitation Services (Prior Approval Required)		
Developmental Services: (Limited to a maximum of 180 units per Covered Person per calendar year)	0%	Not Covered
Outpatient Habilitation Services: Physical, Occupational, and Speech Therapy; and Chiropractic Services (Limited to 30 aggregate visits per Covered Person per calendar year)	$0	Not Covered
Mental Illness and Substance Use Disorder Services		
Inpatient Hospital Services – Semi-private room- (Prior Approval Required)	$0	0%
Partial Hospitalization- (Prior Approval Required)	$0	0%
Residential Treatment Centers (Prior Approval Required) Limited to 60 days per Covered Person per calendar year.	$0	0%
Outpatient (consultation, evaluation, psychotherapy only)	$0	0%
Outpatient Other services and procedures provided in office or outpatient facility	0%	0%
Durable Medical Equipment (DME) and Medical Supplies (Prior Approval for DME for which cost exceeds $500)	$0	0%
Prosthetic and Orthotic Devices and Services (Prior Approval on any device for which cost exceeds $5,000)	0%	0%
Diabetes Management Services		
Diabetic Supplies, shoes (per Medicare guidelines) and equipment	0%	0%
Diabetic Self-Management Training (Allowance or Allowable Charge of $250)	$0	0%

COVERED BENEFITS AND SERVICES (CONT.)	In-Network	Out-of-Network
Skilled Nursing Facility -Prior Approval Required (Limited to 60 Days per Covered Person per calendar year)	$0	0%
Home Health Services (Prior Approval Required) (Limited to 50 visits per Covered Person per calendar year)	0%	0%
Hospice Care (Prior Approval Required)	0%	0%
Dental Care Services Damage to non-diseased teeth due to accident	0%	0%
Reconstructive Surgery (Prior Approval Required)		
Correct defects due to Accident or Surgery.	0%	Not Covered
Reduction Mammoplasty (Prior Approval Required)	0%	Not Covered
Pediatric Vision- 1 pair of glasses with lenses/contacts per calendar year	0%	0%
Medications		
Hospital or Ambulatory Surgical Center	$0	0%
Physician's Office (PCP only)	$0	0%
Retail Pharmacy (Drug Store) or Mail Order (maintenance 90 day supply)		
Preventive Medications	$0	Not Covered
Generic Medications	$0	Not Covered
Preferred Brand Name Medications	$0	Not Covered
Non-preferred Brand Name Medications	$0	Not Covered
Specialty Pharmacy (Prior Approval Required)		
Preferred Specialty Medications	0%	Not Covered
Non-preferred Specialty Medications	0%	Not Covered
Home Infusion Therapy Pharmacy - Injectable Medications	0%	0%
Organ Transplant Services (Prior Approval Required- except kidney and cornea transplants.**)**	0%	0%
Medical Disorder Requiring Specialized Nutrients or Formulas (Prior Approval Required)	0%	0%
Hearing Aid Benefits - $1,400 per Ear per Covered Person.	0%	0%
Temporomandibular Joint Benefits	0%	0%
Miscellaneous Health Interventions	0%	0%

NOTE:

In-Network Services for which the Covered Person has a Coinsurance responsibility are subject to the In-Network Deductible, in most cases.

Out-of-Network Deductible and Coinsurance amounts do not apply to the In-Network Deductible or Annual Limitation on Cost Sharing. Expenses incurred for services that exceed specific benefit limits are not applied to the Annual Limitation on Cost Sharing.

The Covered Person is responsible for difference between billed charges and the Allowance or Allowable Charges for services covered at the Out-of-Network benefit level.

Please note that Prior Approval does not guarantee payment or assure coverage; it means only that the information furnished to us at the time indicates that the service or equipment meets the Primary Coverage Criteria set out in your Policy.

All Covered Services are subject to the Arkansas Blue Cross and Blue Shield Allowance or Allowable Charge.